Yale Journal of Health Policy, Law, and Ethics

Volume 2
Issue 1 *Yale Journal of Health Policy, Law, and Ethics*

Article 13

2002

Compassion and Integrity in Medical Education

Mary Catherine Beach

Daniel E. Ford

BOOK REVIEW

Compassion and Integrity in Medical Education

Mary Catherine Beach, M.D., M.P.H.* and Daniel E. Ford, M.D., M.P.H.†

Ward Ethics: Dilemmas for Medical Students and Doctors in Training. Edited by Thomasine K. Kushner and David C. Thomasma. *Cambridge: Cambridge University Press,* 2001. Pp. 284.

The process of medical training is grueling. *Ward Ethics: Dilemmas for Medical Students and Doctors in Training* (*Ward Ethics*) deals with the daily dilemmas faced by trainees as they struggle to respond to exhaustion, personal insecurities, the suffering of patients, and unethical behavior on the part of supervisors. Most of the cases in the book are not classic ethical dilemmas in the sense of there being uncertainty about the morality of a situation. The book is so filled with examples of unethical behavior that we wonder if anyone reading it would ever agree to see a doctor again. Instead, the dilemmas here focus on how the trainee should respond to unethical situations, and therefore, the issues are important ones.

The prototypical case in *Ward Ethics* is written from a medical student's perspective and reports on an episode where a patient is treated badly; the patient is either lied to, referred to with derogatory terminology, treated with disrespect, treated without adequate consent, or treated ineptly. The student responds with horror or sadness, is generally not in a position to provide any remedy, and wonders what to do. The prototypical commentary following these cases confirms the "wrongness" of the incident, sometimes explains why the behavior is wrong, and sometimes provides an explanation for why these situations exist.

Although one may be tempted to conclude that the behavior described in the book rarely occurs, consider one study's sobering finding

* Mary Catherine Beach is a Greenwall Fellow in Bioethics and Health Policy at the Johns Hopkins University Bloomberg School of Public Health and a Fellow in the Division of General Internal Medicine at the Johns Hopkins University School of Medicine.

† Daniel E. Ford is an Associate Professor in the Division of General Internal Medicine at the Johns Hopkins University School of Medicine and an Associate Professor in the Department of Health Policy and Management at the Johns Hopkins University Bloomberg School of Public Health.

that 40% of senior students did not believe that their teachers behaved as humanistic caregivers with patients or were good role models for the doctor-patient relationship.[1] That the medical trainees in *Ward Ethics* are more sensitive towards the patient than the senior physician is not surprising. Others have observed that students are naturally receptive to patients' emotions.[2] William Branch writes that "[s]tudents arrive on the wards idealistic. Because they are new, they may also feel like outsiders, and thus relate to some of the emotions that patients experience in the unfamiliar hospital environment."[3]

As students learn the technical skills needed to become physicians, they sometimes lose their receptivity towards patients. They are subjected to dehumanizing treatment such as sleep deprivation, verbal abuse, and humiliation.[4] To avoid abuse, and perhaps to become less afraid, students strive to 'fit in' and model their behavior after their supervisors. Branch notes that "[t]his suppression of empathy not only prevents moral development but may even erode existing moral values. In addition to their own suppression, young doctors are assimilated into a ward culture that does not value empathy."[5]

What can be done, then, to cultivate the natural compassion and receptivity of medical students? First, students should be treated humanely. Providing students with protected time for reflection in small groups is one way to support students and demonstrate the value of self-awareness.[6] However, any complete address of this situation would involve broad cultural change and would take a sustained effort on the part of any medical school or residency training program. Branch recommends establishing a climate of humanism in which students' natural compassion is nurtured through positive role modeling in clinical rotations.[7] Although such an effort would take time, there is some evidence that these efforts can be successful.[8]

Ward Ethics attempts to address these issues and could be used as a text book for medical students. The book is divided into seven sections. Section One, entitled "Performing Procedures," deals with a complex array of issues such as the trainee's responsibilities for informing patients about their level of experience when performing procedures; performing physical exams on patients for practice or to demonstrate an interesting physical finding; performing procedures with inadequate supervision; practicing procedures on the newly dead; and observing senior physicians treat patients insensitively by disregarding a patient's pain, breaking a patient's confidentiality, or blaming a patient for their condition. Section Two entitled "Problems in Truth-Telling," covers errors of omission, such as nondisclosure of medical errors and withholding medical information

from patients, and errors of commission, such as lying to supervisors.

Section Three, "Setting Boundaries," deals with sexual relationships with patients, empathy, and compassion. The chapter on compassion is particularly good. Our only criticisms are that this chapter falls under the "Setting Boundaries" section (perhaps implying that compassion is a boundary violation) and that the title, "The Limits of Compassion," may more appropriately be phrased as a question, "Are There Limits to Compassion?" since it seems more a topic for debate than a forgone conclusion. In fact, the importance of maintaining compassion is conveyed within each of the commentaries. For example, Guy Micco writes:

> My answer to the question...—'are there limits to compassion?'—would seem to be 'no,' except for those limits imposed on us by time and other obligations. Yet we physicians have been brought up with the notion that too much 'feeling with' our patients is dangerous—for them and for us.[9]

Richard Martinez provides a thoughtful analysis of compassion as an emotional virtue. He writes:

> Compassion, along with other professional virtues, is an important element in providing good patient care....I have rarely seen reason to discourage other health professionals in their cultivation of this quality. While learning to set limits on one's self and one's patients is an important component of professional development, remaining humanly connected to our patients and our work is vital.[10]

Section Four, entitled "Abuse and Mistreatment," deals with psychological abuse, physical abuse, and sexual abuse of trainees by their supervisors. We believe these issues should be confronted, but we were disappointed by the commentaries on sexual abuse of female students. Although neither of the two commentaries actually endorses sexual harassment, both seem resigned to its existence. Neither commentary expresses the outrage necessary to validate the emotional humiliation of women who have experienced sexual aggression or calls upon anyone to take responsibility for it. We wish the editors had included the opinion of someone who seemed more willing to take on the status quo.

In the first commentary, for example, Domeena Renshaw acknowledges that sexual harassment is unethical and inappropriate. She refers to the example of the surgeon who embarrasses a female medical student in the operating room with a group of snickering male surgeons by asking her suggestively, "[W]hich do you like best, 4 [inches] or 6 [inches]?" (referring to her preference for retractor length) as an example of a "soft" sexual innuendo.[11] Renshaw provides examples of clever retorts

(for example, "are you just a 1 inch?"), which imply that this is a better way to handle the situation than to report the perpetrator. Renshaw further cautions female students that reporting sexual harassment is often more trouble than it is worth. While we agree that students should be forewarned, Renshaw might also have more explicitly addressed the unfairness of a system in which a student risks further humiliation by reporting sexual abuse.

In the second commentary, Evert van Leeuwen also seems resigned to the existence of sexual harassment. He believes that medicine arouses erotic feelings that are necessarily repressed in the assumption of professional demeanor. Because of these repressed feelings, and because physicians rarely have training in sexology,[12] male physicians take these feelings out on their female colleagues. He writes, "[t]he more mental and rational they have to be in their encounter with patients, the more likely they may look for an escape in meeting young, vulnerable, not-yet-colleagues, like trainees."[13] His focus on repressed sexuality as motivation for sexual harassment ignores the possibility that sexual harassment can also be motivated by violence and hostility towards women. The solution, according to van Leeuwen, is "that moral training of physicians should deal with persons of flesh and blood and not only with...politically correct, rational thinking brains."[14] It is true that these issues should be addressed in the moral education of physicians. However, while we wait for that moral education of physicians to take effect, we would advocate for a more immediate solution by developing "no-tolerance" policies and punishing those who abuse women.

Section Five, "Argot, Jargon, and Questionable Humor: Assuming the Mantle at the Patient's Expense," focuses on mordant humor and derogatory patient references. Section Six, "Making Waves: Questioning Authority and the Status Quo," deals with issues related to the premature assumption of the title 'doctor,' duties to treat patients even at personal risk, observing senior physicians deliver poor medical care through neglect and ineptitude, treating patients with inadequate supervision, lying to patients, acting against authority, competing with peers, and conflicts of interest. This final chapter about conflicts of interest contains two well-written and persuasive commentaries by James Weber and Carson Strong focusing on gifts to physicians from the pharmaceutical industry.

One commentary in the "Duties to Treat" chapter involves a young female medical student who is called to the radiology department and asked to stand in the room with a patient while the patient (whom she has never seen before) has a CT scan. The medical student believes she is being used improperly (all of the other physicians and staff are standing in

a different room to avoid exposure to radiation) and stumbles on a lie (pregnancy) that allows her to back out of the situation. We suppose that the inclusion of this case in the "Duties to Treat?" chapter is meant to be an example of when that duty does not exist, however it could equally have been included in the chapter on physical abuse. The first commentary appropriately identifies this as a case of extreme abuse, however, in the second commentary, Neal Cohen writes:

> [N]o practitioner should lie to get out of a situation in which they feel uncomfortable. The medical student should expect that the risk will be defined and that appropriate protective measures offered. If they are not, the student should decline participation and, if necessary, discuss the concerns raised by the case with a supervisor. The student should be willing to describe their discomfort and discuss ways in which to ensure that the patient's care is optimized....[15]

Cohen's focus on the medical student's lie as a disturbing feature of the case seems misplaced and his advice that she should discuss her feelings with a supervisor overlooks the fact that it was her supervisor who asked her to expose herself to an unnecessary dose of radiation.

Section Seven is entitled "Perceiving Misconduct and Whistle-Blowing: Observing Peers or Superiors Commit an Act Deemed Unethical" and deals with substance abuse, rude behavior towards patients, nondisclosure of medical errors, the delivery of poor medical care by senior physicians, and misrepresenting research. The first chapter, which focuses on physician's abuse of drugs or alcohol, contains two thoughtful essays. In the first, Rosamond Rhodes observes:

> Although a few instances of blatant inappropriate behavior are addressed, for the most part, misconduct is ignored. Although venues for employee grievances and hearing complaints...can now be found at many institutions, they are seldom used. In sum, medicine has failed to create an effective mechanism for addressing unethical behavior.... Whistle-blowers are ostracized, pressured to drop allegations, and threatened with counter allegations.... If faculty members are at such risk, the peril for a resident must be far greater, and everyone knows it.[16]

Rhodes then goes on to argue, "[t]o affect such a change in the status quo, the incentives for addressing problematic behavior have to be changed."[17] Given the number and variety of egregious incidents described in this book, Rhodes' observations in this essay are relevant to almost every case in the book.

Ward Ethics draws its cases from around the world. One potential

benefit of this approach is that, for the most part, the experiences that medical trainees undergo seem to be largely the same in any country (e.g., observing disrespectful treatment of a patient and dealing with death for the first time) and there may be some value to the recognition of the universality of this experience. A potential risk of drawing on international examples is that trainees in the United States may find some of the international examples (e.g., performing surgeries without any supervision or dealing with the social consequences of British colonialism in India) unrealistic or dismiss them as irrelevant. For example, legal requirements, such as informed consent, and cultural expectations may differ from country to country.

The format of the book is a series of several cases followed by two or three commentaries. One general criticism about the book was its organization. The cases were not always grouped together for obvious reasons, making some of the commentaries a little diffuse. We also had some trouble understanding the organization of the chapters into sections. For example we did not think the chapter on blaming the patient or violating patient confidentiality should necessarily have been in the section entitled "Performing Procedures." We also did not think that the section entitled "Making Waves: Questioning Authority and the Status Quo" was different than the section on "Perceiving Misconduct and Whistle-Blowing."

Despite these criticisms, we believe that the book addresses important issues in thoughtful ways. While we were disappointed by the content of a few of the commentaries, many of the essays are interesting, and the cases themselves can serve nicely as foci for discussion in medical student curricula. We hope that medical education will continue to evolve such that the scenarios described in this book are confronted and the moral intuitions of medical students are nurtured.

References

1. Brigitte Maheux et al., *Medical Faculty as Humanistic Physicians and Teachers: The Perceptions of Students at Innovative and Traditional Medical Schools*, 34 MED. EDUC. 630-34 (2000).

2. William T. Branch, *The Ethics of Caring and Medical Education*, 75 ACAD. MED. 127 (2000).

3. *Id.* at 129.

4. K.H. Sheehan et al., *A Pilot Study of Medical Student 'Abuse': Student Perceptions of Mistreatment and Misconduct in Medical School*, 263 JAMA 533 (1990).

5. Branch, *supra* note 2, at 129.

6. Branch, *supra* note 2.

7. William T. Branch et al., *Teaching the Human Dimensions of Care in Clinical Settings*, 286 JAMA 1067 (2001).

8. Kathryn M. Markakis et al., *The Path of Professionalism: Cultivating Humanistic Values and Attitudes in Residency Training*, 75 ACAD. MED. 141 (2000).

9. Guy Micco, *Commentary*, *in* WARD ETHICS: DILEMMAS FOR MEDICAL STUDENTS AND DOCTORS IN TRAINING 117 (Thomasine K. Kushner & David C. Thomasma eds., 2001) [hereinafter WARD ETHICS].

10. Richard Martinez, *Commentary*, *in* WARD ETHICS, *supra* note 9, at 116.

11. Domeena C. Renshaw, *Commentary*, *in* WARD ETHICS, *supra* note 9, at 148.

12. Evert van Leeuwen, *Commentary*, *in* WARD ETHICS, *supra* note 9, at 151.

13. *Id.*

14. *Id.*

15. Neal Cohen, *Commentary*, *in* WARD ETHICS, *supra* note 9, at 182.

16. Rosamond Rhodes, *Commentary*, *in* WARD ETHICS, *supra* note 9, at 217.

17. *Id.* at 218.